CAPITAL REGIONAL
CANCER CENTER

Patient Label:

I, the undersigned, hereby consent to the following Treatment:

- History and Physical Examination
- Administration of any needed anesthetics if needed during examination, i.e. laryngoscopy
- Performance of diagnostic procedures/tests and cultures
- Medically necessary lab work or diagnostic test may be ordered based on the judgment of the attending physician.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. I understand that **Capital Regional Cancer Center** may include this consent at satellite offices under common ownership. I, the undersigned, authorize **Capital Regional Cancer Center** and the physicians use and disclosure of my information for the purposes of treatment, payment, and healthcare operations as described in **The Notice of Privacy Practices**.

I understand my personal healthcare information may be released to any person or entity liable for payment on my behalf in order to verify coverage or payment questions, or for any other purpose related to benefits or payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. Information released to any person or entity liable for payment including Medicare and Medicaid may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, radiation treatment notes, psychological and/or psychiatric reports, drug and alcohol treatment. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information, concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that **Capital Regional Cancer Center** will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative. **A photocopy of this consent shall be considered as valid as the original.**

I acknowledge that I have been given the Capital Regional Cancer Center **Notice of Privacy Practices**. I understand that if I have questions or complaints that I should contact the Facility Privacy Official.

Patient Initials_____ Date_____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature Date

_____ _____

Witness Signature Date